HB - 173: SUSTAINABLE HEALTH FOR ALL MONTANANS

EXHIBIT 1
DATE 2/2/09
HB 173

Public Health Survey of Small/Frontier Counties

In August of 2008, Granite and Mineral Counties conducted informal research by selecting a random sample survey of Montana's local health departments having a population of 5000. The survey sought to determine the extent of the Home Health (HH) and Public Health (PH) service challenges in 21 of Montana's counties - 38%, or 104 incorporated cities and towns (noting that 53% of Montanan's reside in counties of less than 28,000 population). The survey was conducted by telephone, reaching 18 of the 21 counties, or 86% response rate.

- 2 of 21 counties described themselves as 'little oil counties.'
- 63% had no HH.
- 37% had 'some' HH.
- 14% were not reached/unavailable.
- 28% had secretarial or administrative support.
- Average PH Nurse available hours (including grant and county supported) 28.9 hours per week.
- 90% cited insufficient funding for PH Nurse programs.
- 100% reported wages below national averages and/or below local hospital pay-scales (1 RN with 34 years of experience reported making $10/hr. for most of her PH career, and only recently began receiving $16/hr., or starting RN wages).
- 100% reported nursing shortages, retention, and recruitment disparities.
- 80% reported insufficient time to complete basic PH programs and duties.
- 76% stated that they were unable to bill for some services because of time, ability or other barriers – 100% of these respondents felt that they could generate revenues for their county if they could bill/bill appropriately.
- 40% cited distance challenges/time spent in travel.

February 2, 2009

The Honorable Jon Sesso, Chairman
Appropriations Committee

Dear Chairman Sesso and Members of the Appropriations Committee,

On behalf of the Mineral County Health Department, and as a frontier Public Health Nurse (PHN), I urge your favorable consideration of HB 173 – Sustainable Public Health for All Montana.

Montana is a unique state where a vast majority of the counties are small or frontier. Many of our frontier counties have little access to health care and suffer high poverty rates. You are acutely aware of the impact to Montanans as a result of recent economic tumult, which now further impact our health care systems. You may also be aware of the long distances some travel for care at our medical centers, yet may not fully realize the level of dependence communities have on their local Health Departments for essential Public Health services.

Public Health Nurses encounter obstacles almost daily in their efforts to assure quality Public Health Service to their communities, the majority of which are economically depressed, isolated, and lacking in essential services. Working with with limited financial, facility, and equipment resources, as well as a shortage of nurses, they strive to provide optimal care, finding it often challenging. Program funding and competitive salary issues continue to daunt their valiant frontier spirit.

In 2008, this became all the more evident, when Mineral/Granite Counties conducted an informal telephone survey, selecting a random sample of Montana Public Health Departments in cities/towns with populations of 5,000 or fewer. From this survey, we identified an alarming lack of PH services for the people residing in the surveyed counties. The cry we heard from nurses in counties across the state brought me before you today in an effort to facilitate a step forward to assure quality Public Health Services for all of Montana.

In these times of economic hardship, access to health care will become more and more difficult. The people, especially the children, who are the future of our great state must be a priority. PH is poised to address health care disparities, and is committed to quality Public Health Services, via improved access to health care. Investing in Public Health will generate a high return on the dollars of Montana taxpayers.

HB 173 will create a more functional, sustainable Public Health practice that benefits the well-being of all Montanans.

Thank you for your favorable support of HB 173

montana public health association
PO Box 511 • Choteau MT, 59422
"Envisioning healthy people in healthy communities - throughout Montana"
Since 1918

February 2, 2009

Representative Jon Sesso, Chair
Appropriations Committee

Dear Chairperson Sesso:

I am pleased to be here today to support House Bill 173 on behalf of the Montana Public Health Association (MPHA). MPHA is an organization with a diverse membership, which includes public health workers as well as partners from other professions; MPHA promotes public health practice and policies in Montana.

H.B. 173 is one of our association's top three priorities this session because we believe that a public health system that saves money gives Montanan's more bang for their buck and improves public health practice throughout Montana. Implementing a system of standards backed by accountability and quality is a win-win situation for all Montanans.

This bill is about local health departments, it's not about the Department of Public Health and Human Services. It's about Pondera County Health Dept, it's about Missoula County Health Dept; it's about Richland County Health Dept. It's about all the county health departments in Montana.

National standards for public health departments are in place. These standards are called the Ten Essential Services of Public Health. These ten essential services are the cornerstone of basic public heath practice.

Nationally we are moving to an accreditation requirement for all health departments. All health departments will be required to meet the national standards. This is a good move. It gives health departments a baseline to operate more efficiently and to look at specific county needs while meeting these standards. In Montana public health will have an "Operational Definition of a Functional Montana Health Department".

HB 173 puts us ahead of the game. The proposed two year pilot project involves eight public health departments of various sizes. It will give these departments the knowledge and experience to meet the national standards and this knowledge and experience will then be shared with other health departments.

Isn't what we want from the money we spend on government programs to have standards, accountability and quality?

I'd like to thank Representative Hendrick and Representative Villa for bringing this important legislation forward and I'd strongly encourage your support.

Sincerely,

Lora Wier

Lora Wier

HB 173- Testimony for Michele Sare, MSN, RN
Lead Public Health Official for Granite County 2/2/2009

Thank you Chair Sesso and Members of the House Appropriations Committee for this opportunity to explain the need for HB 173 – Appropriation for rural Montana healthcare delivery assistance pilot project - to assure for sustainable Public Health (PH) for all of Montana. I am speaking to you now as a frontier county Lead Public Health Official (translates to 'only one').

"According to McKinsey & Co. as of 2008, the average Fortune 500 Company will spend as much on health care as they make in profits"[1]. Our health care system is ranked 37th worldwide, yet we spend over 15% of our GNP on that very healthcare[2]. A cardinal solution set is glaringly obvious and has been in place since 1915[3] – instead of constantly treating disease and injury – prevent them: "Keeping people healthier is one of the most effective ways to reduce healthcare costs"[4]. Public Health is the foundational entity that promotes health and works to prevent disease.

PH is exciting – I love PH and all that I am charged to do for my friends, neighbors and community – in my 33 years as an RN, I have spent over ten years in PH. We can impact the horrific healthcare costs – PH knows how to keep people healthier and how to improve years and quality of life. It is an exciting and valuable profession!

When I took my current PH job 1 ½ years ago there were no policies and procedures, no forms for immunizations, home visits, employee records, how to change voice mail, cell phone passwords or any other basic business function processes. About six months into the job, home health pulled-out of our county and I suddenly became the 'home health' nurse in addition to my duties of running a one person show managing several different programs: immunizations, maternal child, FICMR, over-seeing respite care aids & HV, epidemiology, home visiting for case management, CPT, flu clinics, PHEP, trying to get an LEPC and BOH started and going, B12 shots, blood pressure clinics and a myriad of other legal, individual and community health concerns. PH in my county was a mess to say the least – not too exciting. I set out to figure-out why our county did not have any operational definitions for a functional local health department and it became my mission to improve PH for our county.

I thought that it was just our little resource challenged county and that maybe something was terribly wrong with me. I needed help. So, I called Peggy Stevens in Mineral Co. and we got talking about solutions; it became evident that the problem was bigger than what we could handle alone – so we contacted our Representatives – for Granite Co. – Dan Villa and for Mineral Co. Gordon Hendrick. We wanted more information – so Peg & I developed a questionnaire with the help of her great staff – and we called 18 of Montana's 22 frontier counties (packet insert page 2 of '*Quick Facts*'). I

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[1] Andy Stern, President of the Service Employees International Union
[2] World Health Organization
[3] Lillian Wald – the founder of modern PH
[4] Trust for America's Health

think that you'll agree that the findings were alarming. No one had an operational definition of a functional local health department and most were struggling with the same conundrums that I was.

Not to be deterred, we became more passionate than ever to find a solution not only for our little county's dilemmas, but now also for the PH nurses and their counties whose stories so deeply touched our hearts; many of whom '*are*' PH – without their dedication, tenacity and passion for their communities, there would be no PH – and in many Montana counties – there would be no healthcare at all if it weren't for these remarkable professionals and their PH department. The grassroots effort that has become HB 173 was born!

There are a great many positive things to say about PH in Montana; we are grateful for the work of our DPHHS and the many fine professionals that support our local efforts; BOH and PH law guide our decisions, but the local PH workforce – especially in our medium, small and frontier counties – comprising 84% of Montana's counties – is struggling for survival. An aging workforce, inconsistent definitions of PH practices and job descriptions, lay Commissions, and unsustainable budgets threaten the viability of Montana's local LHJ.

HB 173 addresses the need to assess the challenges facing LHJ and discover and develop ways to create sustainable PH for all Montana – regardless of demographics – to define n operational definition of a local health department and help their constituents to have improved years and quality of life…and save money too: The role of Public Health in Montana is to prevent disease and injury, promote optimal wellness and to protect individuals, families and communities from healthcare risks - for just $10 per person per year, public health can help Montana to realize a savings of $51,000,000 in five years[5]! We're just asking for $1.10 per person per year over the biennium to establish a sustainable model of PH for all Montana. Please talk to your local PH workforce – they are your everyday heroes steadfastly helping to improve the safety and wellbeing of your community.

Thank you for this opportunity and for all of the work that you do on behalf of Montanans.

Respectfully submitted by,

Michele Sare, MSN, RN – LPHO for Granite County

[5] Trust for America's Healthcare: *Prevention for a Healthier America*: 2008

February 2, 2009

Dear Appropriation's Chair Sesso and Representatives;

We would like to introduce the tenets of **HB 173** - 'Sustainable Public Health for All Montanans';

Co-Sponsored by Representatives G. Hendrick (R) and D. Villa (D)

Purpose: There are three levels of Public Health in every state: Governance (such as Boards of Health), Systems (such as our MT DPHHS) and local. This bill seeks to improve and strengthen ***local*** Public Health (PH). **HB173 - Appropriation for rural Montana healthcare delivery assistance pilot project** (*Sustainable Public Health for All Montana)* is a grass-roots effort that seeks to create a 2 year pilot program, administered by DPHHS, involving 8 Local Public Health Jurisdictions (LPHJ) of varying size (with at least one tribal), to:

- Determine what Local Health Departments (LHD) need in order to perform essential public health functions (as defined by the *National Association of City and County Health Officials* [NACCHO] and national standards from the *Centers for Disease Control* [CDC] and *Public Health Accreditation Board* [PHAB])

- Montana has not legislatively adopted a standard for Local Health Departments that defines what a 'functional health department' looks like across the state. HB 173 will support 8 counties to pilot the '*Operational Definition of a Functional Health Department*' from NACCHO – and utilize the NACCHO Assessment Tool

At the completion of the 2 year project the 8 counties, the PH Improvement Task Force and DPHHS will evaluate the discovered strengths, weaknesses and needs necessary to implement an 'Operational Definition of a Functional ***Montana*** Health Department' statewide.

(The PH Improvement Task Force will direct the progress and deliverables)

Current Situation: PH saves money by preventing disease and improving access to care. Local PH assures healthcare services for their population, assesses community health, develops policy to improve health, provides measures to protect communities from health threats and enforces PH law. Many of Montana's Local Health Jurisdictions (LHJ) (Local Health Departments) lack standardization of basic functional practice; fundamental practice guidelines, based on evidenced based practice such as the '*10 Essentials*', the American Nurse's Association's *Standards and Scope of Practice for Public Health* and CDC's *National Public Health Performance Standards* can not consistently be implemented at the local level because of this lack of understanding,

continuous change in public leadership, shifting county budgets and miss-understandings about PH practice – there is no statewide operational definition of a functional local health department . There is no consistent model of PH functions across the state; large jurisdictions have been better able to create a functional sustainability, but medium, small, and frontier LHJ struggle daily to maintain a competent workforce, attempt to complete excessive workloads with little or no support staff and are engaged in an ongoing exertion to justify their work to BOH and Commissions that lack healthcare expertise.

Necessity of policy change: Montana does not have a sustainable model of ***local*** PH, but the need is great:

- Montana is a unique state where 84% of all counties are small or frontier with populations of 20,000 or less
- 51 of Montana's 56 counties are designated as Health Professional Shortage Areas
- 53 of Montana's 56 counties are designated as Medically Underserved Areas
- 90% of these counties have poverty levels of 15% or greater
- There is a LHD in all but four of Montana's counties
- In some counties this is the only medical service available in a 6o+/- mile radius
- With an economy and health care system that is fractured and segmented and long distances to medical centers people living in these communities depend on their LHD for essential health services
- Targeting prevention and maintenance health care are the best ways to create a functional and sustainable health care system; beginning with PHN and LHD that are already established and vested in the community
- PH is poised to address the health care disparities in Montana and is charged with improving access to health care for all Montanans. PH services are cost effective and efficient
- Local PH is supported by county mill levies or federal grant monies. LHJ are supported by as much as 50% federal dollars. If and when these grants go away or are decreased, local PH will face even greater sustainability challenges
- The majority of Montana's small and frontier LHJ are *unable* to bill for services (workload, expertise, Commission support)
- Basic PH services are inequitable across Montana's county lines

Benefits of HB 173 Sustainable Public Health for All Montana: This bill serves **five** cardinal purposes:

1]. **Sustainable** (financial and process) support for all Montana PH departments – regardless of size or economy

2]. **Standardization of PH practice** across the state based on population assessment (basic services that all citizens can expect; record keeping and documentation, processes and quality initiatives to support practice; creation of a PH system where there is no need for fundamental practices to be re-designed county-by-county – currently a tremendous human resource waste = financial waste)

3]. **Improved PH** for all Montanans

4]. **Alignment** with system, governance and LPHJ standards for accreditation: All Montanans deserve the same standards of excellence in PH practice regardless of county size or economy

5]. **Support** for a *vital Montana healthcare workforce*: Public Health

Key Provisions of HB 173:

- The pilot project will assess the challenges and barriers to creating a sustainable model for local PH – regardless of population
- Develop strategies to address discovered challenges and barriers
- Strengthen a vital Montana workforce
- Strengthen fundamental healthcare infrastructure statewide
- Prepare the state's local PH workforce for PH accreditation and the achievement of PH competencies
- Create a sustainable model of local PH for Montana
- Prevent, promote, protect and assist *All Montanans* to live well
- Create an operational definition for Montana local health departments to be used as a guide for LHJ and local Commissions and BOH

*The most important thing is to support a sustainable model of public health for all Montanans; the end result is consistency in public health to **assess, set policy,** and **assure** for **improved health** for Montana's families and communities.*

HB 173: 'Sustainable Public Health for all Montana'

HB 173 is supported by the Montana Public Health Association (MPHA) and the Association of Montana Public Health Officials (AMPHO)....and importantly – by Public Health Nurses and the PH workforce in your community.

AMPHO Association of Montana Public Health Officials Public Health Prevent. Promote. Protect.

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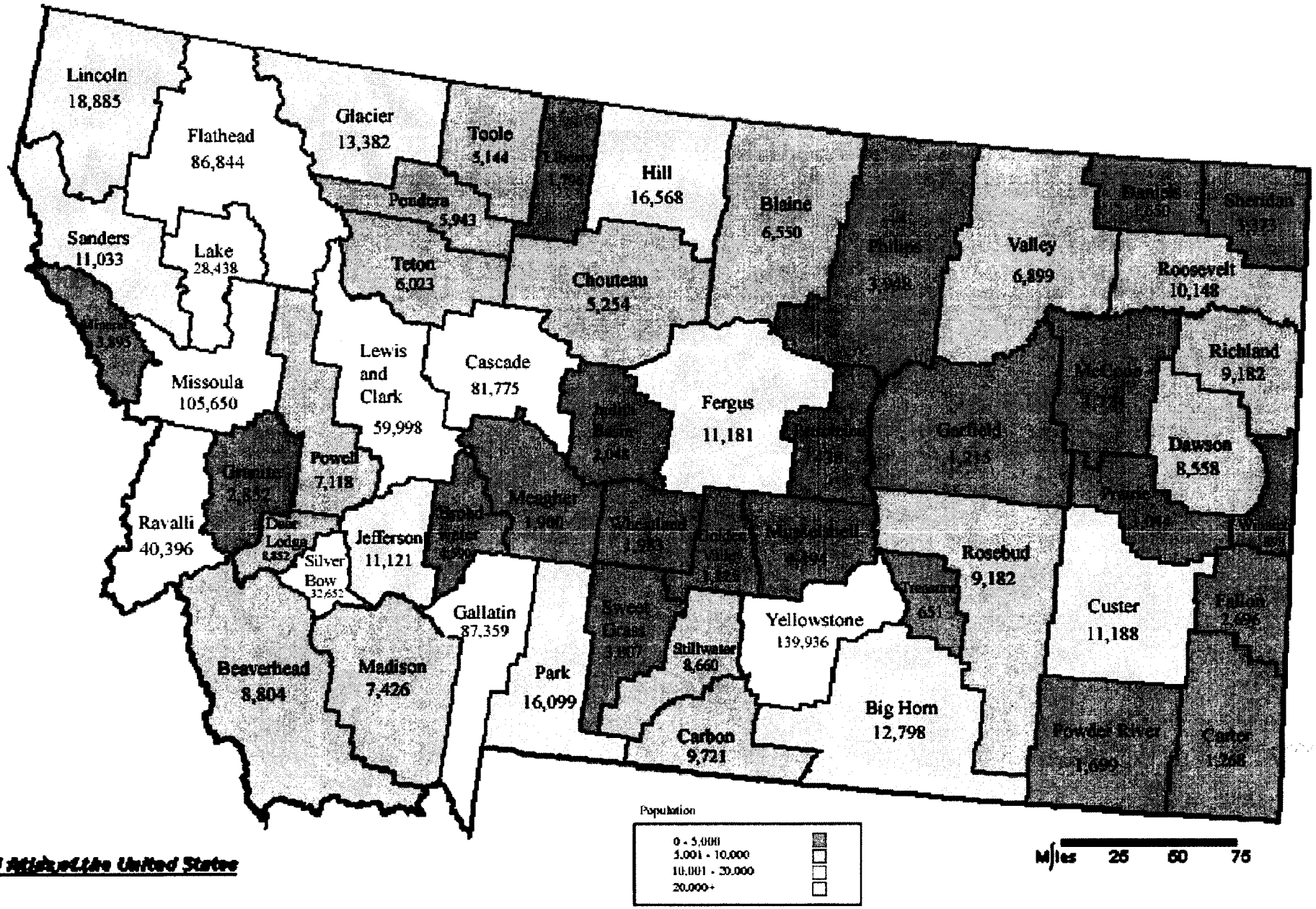
Villa, Dan (D)

Staff: Jon Moe, 406-444-4581

Respectfully submitted by,

Michele Sare, MSN, RN – Granite County, Peggy Stevens, BSN, RN – Mineral County and

Julie Serstad, MSN, RN – Missoula City-County



National Atlas of the United States

Public Health Survey of Small/Frontier Counties

In August of 2008, Granite and Mineral Counties conducted informal research by selecting a random sample survey of Montana's local health departments having a population of 5000. The survey sought to determine the extent of the Home Health (HH) and Public Health (PH) service challenges in 21 of Montana's counties - 38%, or 104 incorporated cities and towns (noting that 53% of Montanan's reside in counties of less than 28,000 population). The survey was conducted by telephone, reaching 18 of the 21 counties, or 86% response rate.

- 2 of 21 counties described themselves as 'little oil counties.'
- 63% had no HH.
- 37% had 'some' HH.
- 14% were not reached/unavailable.
- 28% had secretarial or administrative support.
- Average PH Nurse available hours (including grant and county supported) 28.9 hours per week.
- 90% cited insufficient funding for PH Nurse programs.
- 100% reported wages below national averages and/or below local hospital pay-scales (1 RN with 34 years of experience reported making $10/hr. for most of her PH career, and only recently began receiving $16/hr., or starting RN wages).
- 100% reported nursing shortages, retention, and recruitment disparities.
- 80% reported insufficient time to complete basic PH programs and duties.
- 76% stated that they were unable to bill for some services because of time, ability or other barriers – 100% of these respondents felt that they could generate revenues for their county if they could bill/bill appropriately.
- 40% cited distance challenges/time spent in travel.

- 88% did not attend state or regional meetings because of time, cost, and distance – and "no one to answer the phone when I'm gone."
- 100% stated that they could provide improved PH services, and perhaps more in-home care, if they had more human resources – either another nurse or secretarial support, but preferably both.
- 88% stated they are considering dropping PH programs due to time, human resource, and fiscal constraints.
- 16% reported having strong support from their County Commissioners
- 88% stated that once they retire from PH, they do not think there will be anyone to take their place - citing unavailable workforce, and that "no nurse today would take a job at this pay at this level of responsibility."
- 1% Masters in Nursing; 60% Bachelors in Nursing; 30% Associate Degree in Nursing; 9% Licensed Practical Nurse) (n=12 counties).
- average county population surveyed was 2,428.6 (n=15).
- PH services provided through the PH departments surveyed included: immunizations 100%; Maternal Child Health minimal in all but 2 counties (11%); tobacco prevention 22%; breast & cervical program 22%; flu clinics 100%; epidemiology 77%; partnered with, or solely provided, school nursing 100%; Public Health Emergency Preparedness 88%; Cancer Coalition/Grant 44%; Agency on Aging 22%; **11% Well-Child**; Family Planning 11%; 100% provided some form of home visiting (HV) of the elderly &/or chronic disease management; Women Infants & Children (WIC) 22% (n=9).
- 4 counties had no PH (20%).
- Of the 4 counties without a PH department – 2 had IHS ,and 2 were serviced by a neighboring county 1 day/week.
- When asked if they could/would offer more PH services, 90% stated that they had "enough on my plate…I don't get everything done as it is."
- 40% used federal grant monies to hire secretarial help, diverting monies that could have gone into direct services to people residing in their county.

- 100% felt that the immunization program was a financial liability to their county, unless all Vaccines for Children immunizations are used, as their county will otherwise end up losing money.
- 100% felt that their county Maternal-Child Health (MCH) program was insufficient - few or no parenting classes, little or no high-risk parenting or childhood interventions.
- When asked to describe their ability to meet the PH needs of their county (options were: meets all, most, some, few, none) 56% reported meeting some; 22% reported most; and 2.2% had no PH department (n=18 counties).
- Respondents stated the top 4 barriers to quality and quantity of PH programs in their county were: 1. Money/insufficient budgets; 2. Absence of qualified billing personnel; 3. Lack of qualified nursing personnel and PH nursing time; and 4. Isolation – distance to other services.
- When asked which PH services are lacking/insufficient because of these barriers, they listed: MCH, teen pregnancy prevention/education, Sexually Transmitted Disease surveillance and education, family planning, breast feeding, high risk infant follow-up, diabetes education/follow-up, stroke prevention, better epidemiology, home visiting, case and care management, alcohol and drug prevention, school nursing and/or improved partnerships with schools, better collaboration with other Home Care agencies, better health education and disease prevention, and Hospice Care. These were some services that the local Health Departments saw a need for, but were not always provided at desired levels because of the aforementioned barriers to PH care.

Quick Facts – Montana Public Health

Prepared by M. Sare, MSN, RN, LPHO for Granite Co. & Peggy Stevens, RN, LPHO for Mineral Co.

8/18/2008

Operational Definitions: 'Montana metropolitan' (large) = 40,000 or >; Montana urban = 20,001 - 39,999 (medium); rural = 5,001 – 20,000 (small); frontier (extra small/petite?) = 5,000 or less: for county population map (attached) please reference http://www.ceic.commerce.state.mt.us/Demog/estimate/pop/City/estplacepop_bycounty_2007.pdf

- 51 of Montana's 56 counties have Health Resource Service Administration (HRSA) designated Health Professional Shortage Areas (HPSA)
- 53 of Montana's 56 counties hold designations as Medically Underserved Areas (MUA)
- 90% of these counties have high poverty levels (15% or >)
- 39% (22) of Montana's counties have populations of 5000 or less
- 29% (16) of Montana's counties have a population of 10,000 or less
- 16% (9) of Montana's counties have a population of 20,000 or less
- All counties with a population less than 20,000 account for **84%** of Montana's counties
- 5% (45,544) of Montanans live in counties with less than 5000 people
- 13% (122,764) of Montanans live in counties with less than 10,000 people
- 13% (122,255) of Montanans live in counties with less than 20,000
- 31% (290,563) of all Montanans live in counties with less than 20,000
- Top ten counties in highest household income in Montana (2000 Census)
  1. Jefferson County ($48,562)
  2. Stillwater County ($45,870)
  3. Gallatin County ($44,600)
  4. Lewis and Clark County ($43,711)
  5. Yellowstone County ($42,971)
  6. Rosebud County ($42,001)
  7. Flathead County ($40,325)
  8. Missoula County ($40,311)
  9. Cascade County ($38,576)
  10. Broadwater County ($38,246)
- Of the top 10 highest county household incomes – 60% are 'Montana metropolitan', 30% are rural and 10% frontier
- 2000 Census: Counties in Montana poverty rate ranges from a high of 32.4% in Roosevelt County to a low of 9% in Jefferson County
- Top ten counties in terms of poverty rate in Montana & total percent of population living below poverty (2000 Census)
  1. Roosevelt County (32.4 percent)
  2. Big Horn County (29.2)
  3. Blaine County (28.1 percent)
  4. Glacier County (27.3 percent)
  5. Golden Valley County (25.8 percent)

6. Petroleum County (23.2 percent)
7. Rosebud County (22.4 percent)
8. Garfield County (21.5 percent)
9. Judith Basin County (21.1 percent)
10. Chouteau County (20.5 percent)

- 100% of the counties with the highest poverty rates are rural or frontier
- Montana's income level is 27.2 percent lower than the median household income in the United States (2000 Census)
- American Indian and Alaska Native race/ethnicity population holds the highest rate of poverty with 38.4 percent of the 2000 residents living in poverty.
- People aged 5 years/under have the highest percent of people living in poverty in Montana; accounting for 22.6 percent of children under 5 y.o. living in poverty.
- 15 - 20% or > of the population in rural and frontier counties are 65 or older
- Demographics (population 'mixture') play a significant role in the assessment of public health services as opposed to strictly considering population numbers
- PH resources are inefficiently and – in many instances – ineffectively – utilized as a result of the many challenges and barriers facing PH Nursing in frontier (5000 or less) and rural (20,000 or less) communities
- Sweet Grass, Meagher, Golden Valley & Judith Basin have no PH departments
- 18 of Montana's 22 counties with a population of 5000 or less surveyed reported:
  - 63% (13 counties) do not have home health
  - 14% (3) were not available
  - Average county population surveyed 2428.6 (n=15)
  - 28% (6) had secretarial or administrative support
  - Average PH Nurse available hours (including grant and county supported) 28.9 hours per week
  - 100% reported wages below national averages and/or below local hospital pay-scales (one RN with 34 years of experience reported making $10/hour for most of her PH career and only recently began receiving $16/hour – without benefits [this is less than starting RN wages statewide])
  - 100% reported nursing shortages; retention & recruitment disparities
  - 80% (17) reported insufficient time to complete basic PH programs and duties
  - 76% (16) stated that they were unable to bill for any services because of time, ability or other barriers – 100% of these respondents felt that they could generate revenues for their county if they could bill/bill appropriately
  - 40% (9) cited challenges related to distance/time spent in travel (only one county has a county vehicle)
  - 88% (19) did not attend state or regional meetings because of time, money and distance – and – 'no one to answer the phone when I'm gone'
  - 100% stated that they could provide improved PH services and perhaps more in-home services if they had more human resources available – either as another nurse or secretarial support; preferably both
  - 88% (19) stated that they were considering dropping PH programs due to time, human & fiscal constraints

- 16% (3) reported having strong support from their county's Commission
- 9% hold LPNs, 30% ADNs, 60% BSN & 1% MSN (n=12)
- 40% used federal grant monies to hire secretarial help, but did not feel that they were able to provide increased direct service tied to the grant funding
- 100% felt that the immunization program was a financial liability to their county unless all VFC is used (related to billing ability, expenses & challenges)
- 100% felt that their counties maternal-child programs were insufficient; few or no parenting classes; little or no high-risk parenting or childhood interventions
- When asked to rate their ability to meet the PH needs of their county (options: meets all; some; few; none) 57% (10) reported meeting 'some'; 22% (4) reported 'most'; 22% (4) had no PH (n=18)
- When asked to rate the top barriers to quality and quantity of PH/PH programs in their county – the top 4 barriers were: 1. *Money/insufficient budgets* 2. *Absence of qualifies billing personnel* 3. *Lack of qualified nursing personnel and PH nursing time* 4. *Isolation – distance to other services*
- When asked which PH services are lacking/insufficient due to these barriers the responses were: MCH, teen pregnancy prevention/education, STD surveillance and education, family planning, breast feeding, high risk infant follow-up, diabetes education and follow-up, stroke prevention, better epidemiology, home visiting, case and care management, alcohol and drug prevention, school nursing and/or improved partnerships, better collaboration with other HC agencies, better health education and disease prevention & hospice. These were some of the services that the LHJ felt were needed, but were not provided because of the aforementioned barriers to PH care.

The '10 Essentials' of Public Health Service
PH Version and the Plain English Version - 2009

PH Version	Plain English Version
1]. Monitor health status to identify community health problems	What's going on in my community? How healthy are we? Are we ready to respond to health problems or threats in my county?
2]. Diagnose and investigate health problems and health hazards in the community	How quickly do we find out about problems? How effective is our response?
3]. Inform, educate, and empower people about health issues	How well do we keep all segments of our community informed about health issues and develop appropriate education and behavior modification?
4]. Mobilize community partnerships to identify and solve health problem	How well do we really get people engaged in local health issues?
5]. Develop policies and plans that support individual and community health efforts	What local policies in both government and the private sector promote health in my community? How effective are we in setting healthy local policies?
6]. Enforce laws and regulations that protect health and ensure safety	When we enforce health regulations, are we technically competent, fair, and effective – what mechanisms are in-place for enforcement?
7]. Link people to needed personal health services and assure the provision of health care when otherwise unavailable	Are people in my community receiving the medical care they need?
8]. Assure a competent public health and personal health care workforce	Do we have a competent public health staff? How can we be sure that our staff stays current, meets standards (competencies), guidelines and ethics of professional PH practice?
9].Evaluate effectiveness, accessibility, and quality of personal and population-based health services	Are we doing any good? Are we doing things right? Are we doing the right things?
10]. Research for new insights and innovative solutions to health problems	Are we discovering and using new ways to get the job done and improve outcomes?

HB 173: 'Sustainable Public Health for all Montanans'
Co-Sponsored by Representatives G. Hendrick (R) and D. Villa (D)

HB173 - Appropriation for rural Montana healthcare delivery assistance pilot project, seeks to create a 2 year pilot program, administered by DPHHS, involving 8 Local Public Health Jurisdictions (LPHJ) of varying size (with at least one tribal), to determine what Local Health Departments (LHD) need in order to perform essential public health functions (as defined by the National Association of City and County Health Officials [NACCHO] and national standards from the CDC and Public Health Accreditation Board [PHAB]). Montana has not legislatively adopted a standard for Local Health Departments that defines what a 'functional health department' looks like across the state. HB 173 will support 8 counties to pilot the '*Operational Definition of a Functional Health Department*' from NACCHO. The PH Improvement Task Force will direct the progress and deliverables.

At the completion of the 2 year project the 8 counties, the PH Improvement Task Force and DPHHS will evaluate the discovered strengths, weakness and needs necessary to implement an 'Operational Definition of a Functional *Montana* Health Department' statewide. This serves five cardinal purposes: 1]. Sustainable (financial and process) support for all Montana PH departments – regardless of size or economy 2]. Standardization of PH practice across the state based on population assessment (basic services that all citizens can expect; record keeping and documentation, processes and quality initiatives to support practice; creation of a PH system where there is no need for fundamental practices to be re-designed county-by-county – currently a tremendous human resource waste = financial waste) 3]. Improved PH for all Montanans 4]. Alignment with system, governance and LPHJ standards for accreditation: All Montanans deserve the same standards of excellence in PH practice regardless of county size or economy and 5]. Support for a vital Montana healthcare workforce: Public Health.

The most important thing is to support a sustainable model of public health for all Montanans; the end result is consistency in public health to ***assess, set policy,*** *and* ***assure*** *for* ***improved health*** *for Montana's families and communities.*

HB 173: 'Sustainable Public Health for all Montana'

Fact Sheet

HB173 and Public Health in Montana

Sustainable Public Health For All Montanans

◇ January, 2009 ◇

What is HB173, and how does that provide sustainable public health for all Montana?

Hb173 will be introduced as a 2 year pilot program administered by the Department of Public Health and Human Services, involving 8 pilot counties of varying size (at least one tribal), to determine what Local Health Departments (LHD) need in order to perform essential public health functions (as defined by the National Association of County and City Health Officials [NACCHO], and national standards from the CDC and Public Health Accreditation Board [PHAB]). Montana has not legislatively adopted a standard for Local Health Departments that defines what a 'functional health department' looks like across the state.

Although the Montana Public Health Law Modernization Act of 2007 lays the foundation for standardizing Public Health (PH), it is time to create a model of consistent Public Health across the state. The bill is co-sponsored by Representative Dan Villa (D) – HD86 and Representative Gordon Hendrick (R)- HD14. The bill will help us move toward accreditation. There are ten essential functions that every PH department must address, but with little support, staff, and funds to do so. If PH can not be defined and the scope of practice delineated, it is neither sustainable, nor can it be strengthened financially. This bill seeks to adopt NACCHO's *Operation Definition of a Functional Health Department* and *Self Assessment Tool* as a means to strengthen LHD. At the completion of the 2 year pilot program an assessment will be done and recommendations made for statewide implementation.

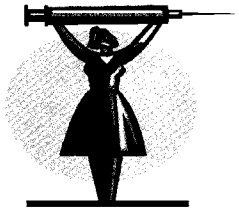
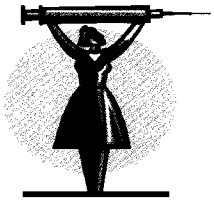
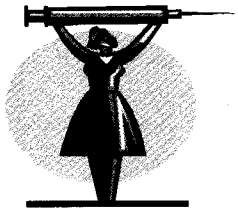
How does this affect Public Health Nursing?

Standardization of LHD is not intended to increase the workload of Public Health Nursing (PHN) rather, to help them to operate more efficiently, and to look at specific county needs while meeting the national standards. Public Health Nurses (PHNs) and LHD staff in Montana are vested in their communities and want the best services for the people who serve. The ten essential services of public health are the cornerstone of basic practice. Defining PH in Montana would set the bar for all counties to aspire to and give some guidelines to commissioners and local boards of health. This would also facilitate budgeting processes to more effectively target those guidelines. *(continued on back)*

HEALTHY PEOPLE 2010

With a definition of standards identified by law, they will have a baseline by which PH is measured and valued. This will enable local health departments to move towards accreditation, provide a measurement tool and strengthen and validate the public health workforce; above all, this will improve public health for all Montanans!

The most important thing is to support a sustainable model of public health for all Montanans; the end result is consistency in public health to assess, set policy, and assure improved health for Montana's families and communities.

Why should your Representative know about HB173?

Montana is a unique state where 84% of all counties are small or frontier with populations of 20,000 or less. 51 of Montana's 56 counties are designated Health Professional Shortage Areas and 53 of Montana's 56 counties hold designation as Medically Underserved Areas. In Addition 90% of these counties have poverty levels of 15% or greater. How does this relate to PH? There is a LHD in all but four of Montana's counties. In some counties this is the only medical professionals available in a 60+/- mile radius. With an economy and health care system that is fractured and segmented and long distances to medical centers, people living in these communities depend on their LHD for essential health services. Targeting prevention and maintenance health care is the best way to create a functional and sustainable health care system, beginning with PHN and LHD that are already established and vested in the community. PH is poised to address the health care disparities in Montana and is charged with improving access to health care for all Montanans. PH services are cost effective and efficient. PHNs practice prevention and know the community and the community members trust and have confidence in them. What better why to provide health care than through strengthened LHD? Why not invest in what is already established instead of reinventing the wheel. By shoring up the foundation of PH though standardizations across the State of Montana, a more functional, sustainable public health practice can be realized that benefits the well-being of all Montanans.

Public Health
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